PROBLEMS RELATED TO RECENT AND PROPOSED CHANGES IN POSTGRADUATE MEDICAL EDUCATION*

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BEFORE discussing some of our problems, I should like to review briefly the present status of graduate medical education in the Army. At present the Army has 1,147 physicians in programs of graduate medical education as indicated in the accompanying table. This is an all-time high. The Army filled 98% of its internships and 95% of its first-year residencies in 1971. The national average has been about 75% and 86% respectively.† In November 1971 our residency selection boards selected applicants to fill 99% of our first-year residency vacancies for 1972. The trend toward an increasing percentage of the Army Medical Corps in graduate medical education programs, as shown in the accompanying figure, has begun to cause us concern. Since we shall have 20% of the Corps in these programs by the end of this fiscal year, compared with about 15% of all physicians in the United States in internships, residencies, or fellowships, we have recently reduced our total number of first-year residencies and fellowships by 25.

Most of our problems concern the status of the internship, specifically its disappearance as a discrete block of training and the concept of a continuum of medical education meaning, really, specialization immediately following, indeed in some cases prior to, completion of medical school. We have had physicians who entered the Army after straight pathology internships who feel that they are unprepared to see patients such as appear on dispensary duty or in the emergency room. We are, however, responding to the trend. In 1972, 54% of our internships will be straight and, for the first time, we shall insert newly graduated med-

*Presented at the 26th annual meeting of the Society of Medical Consultants to the Armed Forces held in Washington, D.C., November 22, 1971.

†*Directory of Approved Internships and Residencies.* Chicago, American Medical Association, 1971-1972.

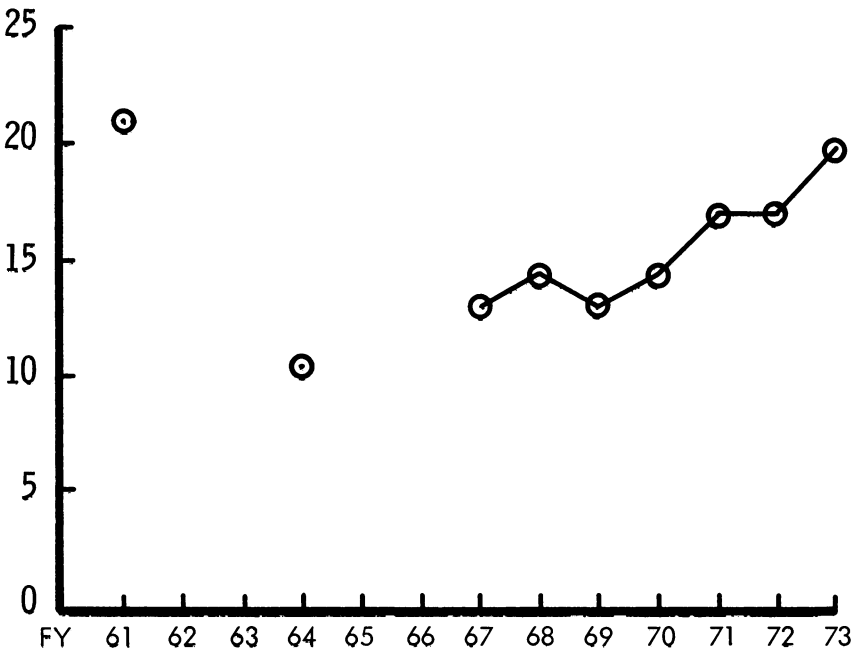
ARMY GRADUATE MEDICAL EDUCATION

October 1, 1971

Interns	194
Residents/fellows	891
USAF Hospitals	4
Civilian Programs	58
Total	1147

ical students directly into residencies in three specialties: neurology, psychiatry, and radiology. Thirteen such positions will be offered in 1972 in order to test the program. Such matching in large numbers will meet with some resistance from our program directors, who have become accustomed to having a strong voice in the selection of their own residents. Further, we must be careful not to commit too many residencies to medical students or even to interns as long as we have former Army interns serving as general medical officers in the field. Ninety-six physicians in this category applied for residencies to begin in 1972, and we feel an obligation to them as long as they apply and are qualified.

The American Board of Orthopaedic Surgery announced in March that the prespecialty year of general surgery was no longer required and that interns would meet their training requirements after three more years of orthopedic residency. Unfortunately, in the preceding November we had selected individuals to start orthopedic training in July 1972 and we had placed them in prespecialty training in July 1971. We can make available only five first-year positions in orthopedics in 1972 where we usually have 18 in a very competitive field. To cushion the impact of this situation on morale we plan to commit one space for July 1973 in each of our six orthopedic programs to the six next best qualified applicants. On-the-job training in orthopedics will also be offered to these six and to as many candidates as we can accommodate. A similar situation results from the new dual-appointment policy of the Conference Committee on Graduate Education in Surgery, but in this case we are forewarned. Our plans are to phase-in dual appointment of straight surgical interns as first-year residents over a four-year period so that we leave room in the surgery programs for general medical officers in the field. Of course we shall have the problem of two aspirants who start their surgical training at the same time, one requiring four years for completion and another five.



Percentages of Army Medical Corps officers in programs of graduate medical education between fiscal years 1961 and 1973.

The Army's anticipated requirement for general medical officers by the end of Fiscal Year 1972 is about 1,500. By far the greatest source of these doctors is the draft or draft-related programs. It is doubtful that there will be a draft of doctors in 1972 and in any case we are committed to a volunteer Army by 1973. Even with the best career inducements under consideration it is apparent that within a few years we shall be unable to meet our requirements for general medical officers, given the trend for early specialization. Some of the deficit can be absorbed by family practitioners and physicians' assistants. We plan to open our first family-practice residency at Martin Army Hospital, Fort Benning, Ga., in July 1972 with 12 residents. The Army's first class of physicians' assistants will begin training in February 1972. It will be an 18-month program leading to the rank of warrant officer, with the goal of training 120 per year to a total of 400. We have been asked to determine the extent to which we can "civilianize" some of the positions that are now filled by medical officers. We think it would be advantageous to civilianize some positions now occupied by general medical officers

at Armed Forces Examining and Entrance Stations and isolated dispensaries. These devices can meet some of our requirements for general medical officers. As for the rest, I think we shall simply have to change our requirements. Some of the work traditionally done by general medical officers may have to be done by specialists, at least for a few years.

Concomitant with the trend toward early specialization is the trend toward subspecialization. More and more of our doctors are requesting fellowship training immediately following their primary residencies. Seventy-three per cent of our medical officers, however, are assigned elsewhere than to our seven teaching hospitals, and our biggest requirement is for basic specialists, not subspecialists. Once a doctor is trained to be, say, a neuroophthalmologist, he is dissatisfied at the station hospital. We shall have to require that many of these officers serve one or two years in their basic specialty from time to time.

I think the trend to integrate osteopaths into the American medical specialities is healthy. The osteopaths in our programs have done well. At present we are training 30:7 interns and 23 residents. We do not have many foreign medical graduates. Only 5% of our residents and none of our interns are graduates of foreign medical schools although such persons comprise about 32% of the nation's house officers. We require all of our house officers to be citizens of the United States.

The law dealing with the salaries of medical officers states that a medical officer is not entitled to special pay while he is serving as an intern. The latest revision of this law was passed in 1962, when the concept of an internship as a discrete block of training between medical school and general practice or residency still prevailed. This concept and, in my opinion, also this provision of the law, is obsolete. But the law is still on the books. We shall have in our programs contemporaries who were graduated from medical school at the same time and who are in their first year of graduate medical education. Some, who happen to be called residents, will be entitled to special pay; others, who still carry the title of intern, will not be permitted to receive this pay. It seems improbable that Congress will act on this matter before July 1, 1972, and I do not yet know how we shall solve the problem.

In summary, our biggest problem is related to the trend for physicians to go into specialty training directly from medical school. This will be compounded by the loss of men obtained through the draft. For their graduate medical educations students will choose institutions from

among those with which they are most familiar or to which they have been exposed. We know that our programs are among the best but, without the draft and the so-called free-standing internship, the opportunities for medical students to see what we have may be seriously limited. The answer is more emphasis on our clinical clerkships and scholarship programs, such as are provided in the Uniformed Services Health Professions Revitalization Act of 1971. In addition, we must become involved even more in less formal affiliations between medical schools and nearby Army hospitals.